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No. 01-1710

IN THE

Supreme Court of the United States

EMPIRE BLUE CROSS AND BLUE SHIELD,
Petitioner,

v.

JOHN F. BYRNES, *et al.*,
Respondents.

EMPIRE BLUE CROSS AND BLUE SHIELD,
Petitioner,

v.

IRMA M. ALICEA, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, INC., THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND THE AMERICAN BENEFITS COUNCIL IN SUPPORT OF PETITIONERS

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Pursuant to Rule 37.2 of the Rules of this Court, the American Association of Health Plans, Inc. ("AAHP"), the Chamber of Commerce of the United States of America (the "Chamber"), and the American Benefits Council (the "Council") respectfully move for leave to file the attached

brief as *amici curiae* in support of Petitioner. Petitioner has consented to the filing of this brief. Its letter of consent has been lodged with the Clerk of the Court. Respondents have declined to consent.

The AAHP is the national association for the managed care community. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans. Its membership includes health maintenance organizations, preferred provider organizations, third party health plan administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 managed health care organizations serving nearly 160 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.*

AAHP files this brief because of its interest in preserving the ability of the managed care community to arrange for quality, affordable health care pursuant to ERISA-covered benefit plans. The Second Circuit's decision would increase both the disclosure requirements and the liability risk under ERISA, which will increase health plan costs, thereby discouraging employers from sponsoring benefit plans.

The Chamber is the world's largest business federation and serves as the principal voice of the business community. The Chamber represents an underlying membership of nearly three million businesses and organizations, in every size, sector and geographic region of the country. An important function of the Chamber is to represent the interests of its members by filing *amicus* briefs in this Court on issues of national concern to American business.

The Council is a broad-based, non-profit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its members also include employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms, and other professional benefit organizations. Collectively, its more than 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

The ability to establish and maintain employee benefit plans at an affordable cost is of vital importance to the members of the Chamber and the Council. The Second Circuit's decision would undermine this ability by imposing vague disclosure standards coupled with increased liability.

For the foregoing reasons, AAHP, the Chamber and the Council respectfully request that they be allowed to participate in this case by filing the attached brief.

Respectfully submitted,

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INTEREST OF *AMICI CURIAE*

The interest of amici curiae, AAHP, the Chamber and the Council, is set forth in the motion accompanying this brief.[1]

[1] Pursuant to Supreme Court Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part and no person or entity other

STATEMENT OF THE CASE

The *amici* incorporate the Statement of the Case in the Petition for Writs of Certiorari and briefly summarize the portions of the opinion of the United States Court of Appeals for the Second Circuit (App. 1a-24a) (Byrnes)[2] relevant to amici's arguments.

As required under ERISA, Petitioner, Empire Blue Cross and Blue Shield ("Empire"), distributed Summary Plan Descriptions ("SPDs") to participants in Empire's life insurance plan. The SPDs described the terms of the plan and stated that the life insurance coverage would continue until the retiree died. App. 4a-6a. The pre-1987 SPD did not recite Empire's right to amend or terminate the life insurance plan. App. 4a-5a. In 1987, Empire revised its SPD to expressly reserve its right to amend or terminate the plan. App. 5a-6a.

Petitioner also distributed to its employees descriptions of two voluntary workforce reduction programs—the "VSOP" in 1992 and the "VIP" in 1993—permitting voluntary resignation in exchange for certain benefits. App. 6a-7a. The VSOP and VIP offered life insurance benefits for retirees on substantially the same terms as the life insurance plan. App. 6a. In the documents describing the VSOP and VIP, there was no language directly accompanying the description of life insurance benefits that recited Empire's right specifically to change the life insurance benefit, but there was general reservation of rights language permitting Empire to

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than *amici* contributed monetarily to the preparation and submission of this brief.

[2] The Petitioner seeks review of two judgments of the United States Court of Appeals for the Second Circuit that involve "identical or closely related questions." Sup. Ct. R. 12.4. *Amici's* arguments focus on *Byrnes v. Empire Blue Cross and Blue Shield*, (one of the two cases). *Byrnes* was captioned *Devlin v. Empire Blue Cross and Blue Shield* below.

amend or terminate the programs and to adopt new or modified programs. App. 6a-7a.

In 1998, Empire amended the insurance plan to reduce coverage for retirees. App. 7a. Upon request of the retirees affected by the change, Empire provided a copy of the then-current, post-1987 SPD, which recited Empire's right to amend or terminate the life insurance plan. App. 24a.

The Court of Appeals concluded that employees who began working for Empire before the 1987 SPD was distributed may have the right to unmodified life insurance benefits for life. App. 15a. The Court of Appeals further found that "[i]n repeatedly describing its life insurance benefit as remaining constant for life, Empire may have violated this [fiduciary] duty to deal honestly with the plan beneficiaries." App. 21a. This, in turn, according to the Court, gave respondents a claim for appropriate equitable relief under section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), as well as claims for benefits under section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B). App. 22a-23a.

REASONS FOR GRANTING THE PETITION

Improperly stretching the boundaries of *Varity Corporation v. Howe*, 516 U.S. 489 (1996) ("*Varity*"), the *Byrnes* decision adds broad and ill-defined disclosure obligations derived from ERISA's general fiduciary duty of loyalty to ERISA's comprehensive statutory disclosure scheme. Also contrary to *Varity*'s guidance, *Byrnes* recognizes a cause of action under section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), for breach of fiduciary duty for violating the new disclosure obligations, even though another section of ERISA provides an adequate remedy.

A broad, undefined, affirmative fiduciary duty to disclose information is unworkable given the complexity of ERISA

fiduciary relationships and unnecessary given ERISA's existing detailed statutory disclosure requirements. Moreover, allowing claims under section 502(a)(3) to proceed simultaneously with more specific ERISA claims that provide adequate relief will lead to additional, wasteful litigation, while providing no additional protections for plan participants. On both issues the *Byrnes* decision conflicts with the law in other circuits. Both issues also broadly affect the ERISA universe—increasing costs, uncertainty and potential liability for employers and unions that sponsor retirement and health plans, as well as third party administrators, financial services firms, and health insurers that provide services to such plans.

The Court should grant the petition to clarify that ERISA's duty of loyalty requires a fiduciary not to lie or affirmatively mislead plan participants, but not more, and to re-establish the limited purpose of section 502(a)(3) of ERISA as a "safety net" remedy, rather than a duplicative remedy. Varity, 516 U.S. at 512.

I. THE *BYRNES* APPROACH TO FIDUCIARY DISCLOSURE DUTIES IS NOT SUPPORTED BY ERISA.

A. Courts Should Not Supplement ERISA's Comprehensive Statutory Disclosure Scheme with Broad and Ill-Defined Disclosure Requirements Under ERISA's General Fiduciary Duty of Loyalty.

ERISA has an "elaborate scheme in place for enabling beneficiaries to learn their rights and obligations at any time, a scheme that is built around reliance on the face of written plan documents." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995); *see* H.R. Rep. No. 93-533, p. 11 (1973); ERISA §§ 101-111; 29 U.S.C. §§ 1021-1031.

A key element of ERISA's disclosure scheme is the requirement that plan administrators distribute to plan participants SPDs written in plain terms understandable to the average participant. *Curtiss-Wright*, 514 U.S. at 83-84; ERISA § 102; 29 U.S.C. § 1022 SPDs must be provided to participants within 90 days of enrollment in the plan, copies of plan amendments must be provided regularly, new SPDs must be issued periodically, the latest SPD must be made available at the plan administrator's principal office and the plan administrator must provide the latest SPD to participants upon request. ERISA § 104(b); 29 U.S.C. § 1024(b). ERISA includes specific civil penalties if SPDs are not provided upon request. ERISA § 502(c)(1); 29 U.S.C. § 1132(c)(1).

In contrast, section 404(a) of ERISA, 29 U.S.C. § 1104(a), imposes traditional duties of loyalty and prudence on plan fiduciaries, modeled on the law of trusts. *Varity Corp. v. Howe*, 516 U.S. at 506. ERISA defines the term "fiduciary" broadly, making any person who has administrative authority or exercises investment discretion with respect to a plan, or who provides investment advice, a fiduciary. ERISA § 3(21); 29 U.S.C. § 1002(21). Under this functional definition, many persons may have fiduciary relationships with plans, in addition to the plan administrator, trustees or specifically enumerated "named fiduciaries." *Mertens v. Hewitt Associates*, 508 U.S. 248, 251-52 (1993).

ERISA is silent on whether its duty of loyalty provision imposes general disclosure obligations on plan fiduciaries to supplement the comprehensive and specific statutory disclosure obligations imposed on plan administrators. This question was partially addressed in *Varity*, where the Court adopted the straightforward but narrow rule that fiduciaries of ERISA plans violate their duty of loyalty if they knowingly and significantly mislead plan participants. *Varity*, 516 U.S. at 506. The Varity Court did not reach "the question of whether ERISA fiduciaries have any fiduciary duty to

disclose truthful information on their own initiative, or in response to employee inquiries." *Id.*

Lower courts have struggled to address the questions left unanswered by *Varity*. Courts have reached disparate results in similar factual circumstances, creating significant uncertainty with respect to disclosure duties and liability for the myriad of persons that serve as plan fiduciaries, including plan sponsors, administrators, trustees, financial services firms and health insurers. *Compare Byrnes*, App. 21a (duty to disclose the company's right to amend in letters describing early retirement program); *Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997) (duty on HMO to disclose physician financial incentives) *with Sprague v. General Motors Corp.*, 133 F.3d 388 (6th Cir.), *cert. denied*, 524 U.S. 923 (1998) (no duty to disclose company's right to amend early retirement program in every communication regarding the program), *Ehlmann v. Kaiser Foundation Health Plan of Texas*, 198 F.3d 552 (5th Cir. 2000) (no affirmative duty on HMO to disclose physician compensation).

Byrnes exacerbates the situation, adopting a vague, unworkable disclosure standard for employers communicating with plan participants. Rather than properly adhering to ERISA's specific disclosure requirements and a narrow reading of *Varity*, the Second Circuit found in *Byrnes* that Empire may have breached its fiduciary obligations by failing to provide information when it allegedly knew its failure would cause harm. App. 21a. In so doing, the court endorsed an *affirmative* duty of disclosure far exceeding ERISA's statutory reporting and disclosure requirements and the narrow fiduciary duty not to affirmatively mislead participants established by *Varity*.

Courts that have imposed broad disclosure obligations under ERISA's general fiduciary provisions have done so in light of the common law of trusts. *E.g., Eddy v. Colonial Life Ins. Co. of Am.*, 919 F.2d 747, 750 (D.C. Cir. 1990). But

"trust law does not tell the whole story." *Varity*, 516 U.S. at 497. This Court has repeatedly made clear that trust law is only a starting point. To determine whether or the extent to which ERISA departs from trust law, "courts may have to take account of competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Id.*[3] Here, the balance weighs against following common law trust requirements in defining a fiduciary duty of disclosure under ERISA.

ERISA's comprehensive statutory disclosure scheme itself represents a major departure from the common law. Common law trustees have certain disclosure obligations, but not the elaborate or comprehensive types of obligations that ERISA imposes on plan administrators.

In their breadth and complexity, ERISA fiduciary relationships also are far removed from traditional common law trust relationships. Common law trustees typically administer a trust that holds property for the benefit of a limited group of persons (*e.g.*, a personal trust or family trust). A person generally does not assume fiduciary status unless he or she accepts designation as a trustee. *See* Restatement § 2; Bogert, Trusts and Trustees § 1 (2d ed. rev. 1992).

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[3] The Secretary of Labor, charged with interpreting and enforcing ERISA's fiduciary rules, reached a similar conclusion, finding that the common law of trusts should not be "mechanically applied to employee benefit plans." 44 Fed. Reg. 37225 (June 26, 1979) (Preamble to regulations under section 404(a) referring to H.R. Rep. No. 1290, 93 Cong., 2d Sess. 302 (1974) (ERISA's Conference Report)).

In contrast, ERISA imposes fiduciary duties in a much broader array of circumstances. *Mertens*, 508 U.S. at 251-52; ERISA § 3(21). Entities not formally designated as fiduciaries that have a relationship with a benefit plan, such as employers who sponsor plans, may become fiduciaries through conduct.[4] Thus, employee benefit plans often have many different fiduciaries with different responsibilities to a constantly changing plan population, which may number in the thousands. And, third party administrators, financial services firms and health insurers that administer and manage retirement and health plans may have fiduciary relationships with thousands of plans and millions of plan participants.

A statutory scheme of disclosure, rather than a general fiduciary standard based on the common law of trusts is the only scheme consistent with ERISA's central goal "to enable plan beneficiaries to learn about their rights and obligations at any time." *Curtiss-Wright Corp.*, 514 U.S. at 83. By giving the plan administrator the responsibility to make specific and clearly defined plan disclosures, ERISA ensures that participants know which person to seek information from and ensures that the plan speaks with one, consistent voice.[5] Moreover, purely as a practical matter, it would be unworkable to require all plan fiduciaries to disclose information above and beyond the statute's specific provisions. It would be virtually impossible for each and every plan fiduciary to know what facts relating to plan operations might be meaningful to thousands of differently situated participants and when disclosures should be made.

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[4] *Varity* illustrates the fact-specific inquiry necessary to determine fiduciary status. There, the Court delved deeply into Varity's conduct and the surrounding circumstances before concluding that the company's conduct transformed it into a fiduciary. 516 U.S. at 498-505.

[5] The plan "administrator," as defined in ERISA, is an entity whose identity can readily be ascertained. ERISA § 3(16); 29 U.S.C. § 1002(16).

Settled principles of statutory construction also suggest that where Congress expressly imposed comprehensive and specific disclosure obligations on the plan's "administrator," the courts should not imply broad, general supplementary duties of disclosure to the universe of all plan fiduciaries. *See Ehlmann*, 198 F.3d at 555-56; *Sprague*, 133 F.3d at 405. The Court followed this path in *Curtiss-Wright*, choosing not to recognize additional disclosure obligations under ERISA's fiduciary provisions. *Curtiss-Wright*, 514 U.S. at 84.

Given ERISA's comprehensive and specific disclosure obligations, where gaps emerge, the courts should resist adopting a patchwork of varying and burdensome disclosure obligations. That is the role of Congress, and it has not shirked that role. ERISA's disclosure rules have not remained static, particularly with respect to group health plans, where numerous changes already have been made.[6]

The ongoing legislative and regulatory efforts to define, and in some cases, expand, the duty to disclose specific, identifiable types of information to plan participants counsels against the approach to disclosure endorsed by the court of appeals. The approach in *Byrnes* "eschew[s] clear rules that might avoid litigation," *US Airways, Inc. v. Barnett*, 122 S. Ct. 1516 (2002) (Scalia, J., dissenting) in favor of an indeterminate set of rules that the courts must draw by

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[6] In this regard, Congress established a specific disclosure rule relating to modifications of group health plans under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as well as specific disclosure obligations under the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Rights Act of 1998. ERISA §§ 104(b), 711(d), 713; 29 U.S.C. 1185, 1185b. Recent changes to regulations governing summary plan descriptions and claims procedures have also substantially enlarged plan disclosure obligations. *See* 65 Fed. Reg. 70226 (Nov. 21, 2000); 29 C.F.R. § 2520.102-3 (SPD regulations); 65 Fed. Reg. 70246 (Nov. 21, 2000); 29 C.F.R. § 2560.503-1 (claims procedure regulation).

analogy from trust law. The Court should grant review to bring clarity to an area that is becoming increasingly muddled.

B. The Second Circuit's Decision Establishes an *Ad Hoc* Standard that Fiduciaries May Not Be Able to Meet.

The Second Circuit found that Empire had a fiduciary duty not to make "affirmative misrepresentations regarding plan benefits" and "to provide completely accurate plan information." App. 21a-22a. Even though Empire's communications to plan participants fulfilled these standards, the court concluded that Empire may have breached a fiduciary duty because it did not make further disclosure of information it already had disclosed. Fiduciaries may not be able to comply with this type of *ad hoc* disclosure standard.

The Second Circuit identified two possible deficiencies in Empire's communications with participants. First, the court found that "in repeatedly describing its life insurance benefit as remaining constant for life, Empire may have violated this duty to deal honestly with the plan beneficiaries." App. 21a. But the 1987 SPD and the VSOP and VIP retiree letters that described the insurance benefit as remaining constant for life also described Empire's right to amend or terminate the benefit. App. 5a-7a. The fact that the retiree VSOP and VIP letters contained a general, rather than a life insurance-specific reservation of rights does not, by any reasonable standard, render them misleading or dishonest.

Even if the general statement in the retiree letters noting Empire's right to amend or terminate benefits were not sufficient disclosure, Empire's right to amend or terminate the life insurance benefit was clearly stated in the 1987 SPD. App. 5a-6a. Failing to repeat all of the information required in an SPD in every communication to participants is not misleading and is not required to satisfy any fiduciary duty

under ERISA's duty of loyalty provision. "There is, in our view, a world of difference between the employer's deliberate misleading of employees in *Varity Corp.* and [the employer's] failure to begin every communication to plan participants with a caveat." Sprague, 133 F.3d at 405.

Finally, the court indicated that giving participants the then-current 1987 SPD upon request may have misled participants because their benefits were governed by the pre-1987 SPD. Even if the participants' benefits were governed by the earlier SPD—and, as petitioner explains, they were not—ERISA requires a plan administrator to provide participants upon request the "latest updated summary plan description." ERISA § 104(b)(4); 29 U.S.C. § 1024(b)(4). Thus, even fiduciaries who comply with ERISA's express disclosure standards could be viewed as having violated the Second Circuit's standard. Adequate disclosure requires clear standards that are consistently applied. *See Curtiss Wright*, 514 U.S. at 83. The Empire decision moves ERISA disclosure in the opposite direction.

II. RECOGNIZING A CLAIM FOR BREACH OF FIDUCIARY DUTY WHERE OTHER, ADEQUATE REMEDIES ARE AVAILABLE IS CONTRARY TO THIS COURT'S GUIDANCE IN *VARITY* AND WILL LEAD TO ADDITIONAL, UNNECESSARY LITIGATION, INCREASING THE COST OF MAINTAINING A PLAN.

The Court has repeatedly emphasized that ERISA is a "'comprehensive and reticulated statute,' the product of a decade of congressional study of the Nation's private employee benefit system." *Great-West Life and Annuity Insurance Company v. Knudson*, 534 U.S. 2004 (2002) (quoting *Mertens v. Hewitt Associates*, 508 U.S. 248, 251 (1993) and *Nachman v. Pension Benefit Guaranty*

Corporation, 446 U.S. 359, 361 (1980)). The Court therefore has been "reluctant to tamper with an enforcement scheme crafted with such evident care. . . ." *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985).

With that background, in *Varity*, the Court recognized section 502(a)(3) of ERISA as a "catch-all" remedy under ERISA's enforcement scheme, providing "appropriate equitable relief for injuries caused by violations that section 502 does not elsewhere adequately remedy." 516 U.S. at 504, 512. The Court limited relief under section 502(a)(3) only to those situations where there is no other adequate remedy. This is because, as a matter of statutory construction, the general relief provided in section 502(a)(3) should not be read to undermine the limitations in more specific provisions that provide, for example, a claim for benefits under a plan (section 502(a)(1)(B)) and a claim for breach of fiduciary duty on behalf of a plan (section 502(a)(2)). Id. at 512. Consistent with this reasoning, the Court recognized an individual claim for breach of fiduciary duty under section 502(a)(3) in *Varity* because the plaintiffs had no other remedy under ERISA.

Unlike the plaintiffs in *Varity*, the plaintiffs in *Byrnes* clearly have an adequate remedy in their claim for benefits under section 502(a)(1)(B). App. 22a-23a. The *Byrnes* decision ignores this, allowing the plaintiffs' overlapping claims for benefits under section 502(a)(1)(B) and for appropriate equitable relief for breach of fiduciary duty under section 502(a)(3) to proceed together. App. 23a. The sole basis for allowing both claims to proceed is that if plaintiffs' claim for benefits fails, then the claim for breach of fiduciary duty will be their only remedy. App. 22a. But this is not the standard that *Varity* established. *Byrnes* changes the "adequate remedy" standard in Varity to a "successful remedy" standard unsupported by the statute or case authority.

If the Court does not correct this erroneous interpretation of *Varity*, plaintiffs will routinely add fiduciary breach claims to their benefits claims. In addition to increasing the number of claims, in many cases, this also will increase the number of parties, as plan fiduciaries are added as defendants for the fiduciary breach claim. The multiplication of claims and parties will, in turn, increase the costs of maintaining benefit plans, to the detriment of plan sponsors and plan participants.

The highly-publicized litigation against the HMO industry filed by prominent class action attorneys illustrates this risk. The HMO actions included ERISA claims under section 502(a)(3) for breach of fiduciary duty for failure to disclose. These claims were dismissed by the district court because plaintiffs' claims could be adequately addressed under section 502(a)(1)(B). *In re Managed Care Litigation*, 185 F. Supp. 2d 1310, 1327 (S.D. Fla. 2002). Unless the *Byrnes* approach is decisively rejected, the HMO litigation and similar cases threatens to cripple health plans with increased costs.

This Court foresaw this risk in *Varity* and tried to limit it. In responding to arguments that allowing claims for individual relief for a fiduciary breach under section 502(a)(3) would wreak havoc with ERISA's carefully crafted enforcement provisions, the Court cautioned that "where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.'" *Id.* at 515.

Most courts to consider the issue have maintained this distinction, recognizing an individual's claim under section 502(a)(3) only where he or she does not have a claim for benefits under section 502(a)(1)(B), regardless of whether the claim for benefits ultimately will be successful. *Compare, e.g., Katz v. Comprehensive Plan of Group Insurance*, 197 F.3d 1084, 1089 (11th Cir. 1999) ("the availability of an adequate remedy for *Varity* purposes, does not mean, nor

does it guarantee, an adjudication in one's favor"); *Tolson v. Avondale Industries, Inc.*, 141 F.3d 604, 610 (5th Cir. 1998) (plaintiff's failure to prevail on his claim for benefits under section 502(a)(1)(B) does not make his alternative claim for fiduciary breach under section 502(a)(3) viable), *with Strom v. Goldman, Sachs & Co.*, 202 F.3d 138, 148-49 (2d Cir. 1999) (recognizing fiduciary breach claim under section 502(a)(3) where plaintiff had no claim for benefits under section 502(a)(1)(B)).

Limiting section 502(a)(3) as required by Varity not only comports with prevailing case law, the structure of ERISA's enforcement scheme and rules of statutory construction, but it also reduces duplicative or frivolous claims that increase the cost of maintaining a plan. This, in turn, preserves the delicate balance Congress sought to achieve between encouraging employers to establish benefit plans and protecting the rights of participants under those plans. *Varity*, 516 U.S. at 497.

CONCLUSION

The petition for writs of certiorari should be granted.

Respectfully submitted,

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